PRINTED: 08/13/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		15G245	B. WING		R
NAME OF PI	ROVIDER OR SUPPLIER	150245	I B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	07/03/2013
ARC OF N	ORTHWEST INDIANA IN	IC, THE		4378 FOURTEENTH LN HOBART, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
{W 000}	INITIAL COMMENTS		{W 00	00}	
	survey to the 23 day 6/4/13 to the extende state licensure to a fu	768 G245			
{W 102}	accordance with 460 Quality Review comp Shackelford, QIDP. 483.410 GOVERNING MANAGEMENT The facility must ensu	so reflect state findings in IAC 9. leted 7/12/13 by Ruth	{W 10	02}	8/2/13
	Based on observation review, the facility fail Participation: Govern clients (#1 and #2). The ensure client #1 and it met and not neglecte	not met as evidenced by: n, interview and record ed to meet the Condition of ing Body for 2 of 2 sampled The governing body failed to #2's heath care needs were d. The governing body			
_ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 000768

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		15G245	B. WING_			R 07/03/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 4378 FOURTEENTH LN HOBART, IN 46342	DE	07/03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
{W 102}	according to the physical governing body failed reported an allegation fall. The governing befacility did not misplated. The governing befacility did not misplated. The governing befacility did not misplated. The governing befacility and procedure regard to the clients' governing body also reported an allegation regard to a fall with it and/or to other state Please see W122. The governing befacility and procedure for 2 of 2 sates of 2 of 2 of 2 sates of 2 of 2 sates of 2 of 2 of 2 sates of 2 of 2 of 2 of 2 sates of 2 of	administered medications sician's orders. The d to ensure the facility of neglect in regard to a pody failed to ensure the ce/lose a client's chart. dy failed to ensure the facility Participation: Client sampled clients (#1 and pody failed to implement its is to prevent neglect in health/medical needs. The failed to ensure the facility of possible neglect in highly in of possible neglect in highly in of possible neglect in highly in a price to the administrator officials regarding client #2. dy failed to ensure the facility Participation: Health Care ampled clients (#1 and #2). If a failed to ensure its Health are health care needs of the ensure governing body failed to are Services assessed, dressed a client's health care abetes. The governing body facility's Health Care Services loctor in regard to the client's discovery services discovery in governing body in the client's discovery in the governing body failed to ensure the facility's serviced/updated the risk lient #2. The governing body	{W 1	02}		
	low and/or high blood governing body failed Health Care Services plan as needed for confailed to ensure the failed to diabetic m	d sugar levels. The d to ensure the facility's s revised/updated the risk				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	' '	TE SURVEY MPLETED
		15G245	B. WING			R 07/03/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 4378 FOURTEENTH LN HOBART, IN 46342		11/03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{W 102}	3. The governing be implemented its writt procedures to preve diabetes as the facilithe client's diabetic refailed to ensure the failed to ensure the failed to ensure the client a variety aper the client a variety aper the client's speciody failed to ensure #2's low and high blooutlined by the client program plan. The gensure the facility's refused to the client's diabetes. The governing body aggressively address appointments and lapotential hospitalizat with the client's diabete failed to ensure the facility and procedure #1 in regard to the control of the control of the control of the control of the governing body reported a fall with in involving client #2, in administrator and to Disabilities Services (5) and to Adult Proton 12-10-3. The governing body nursing services reviplan for his diabetes to ensure the facility.	dy failed to ensure the facility ten policy and written not neglect of client #2's ty neglected to update/revise isk plan. The governing body facility monitored the client's of ensure facility staff offered and adequate amount of food fied diet. The governing enthe facility monitored client bod sugar readings as the prescription of the facility monitored client on a more frequent basis. It is physician's order and/or governing body failed to nursing services monitored on a more frequent basis. It is physician's refusals of the client's refusals of the client's refusals of the client's result of the stop prevent recurrence of the same the facility implemented its written the stop prevent neglect of client the stop prevent neglect of client the same the facility injury/possible neglect,	{W 10	2}		

INVESTMENT OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE INDIANATION OF SUPPLIER ARC OF NORTHWEST INDIANA INC, THE SERVED BY SUPPLIER SUPPLIER ARCH DEPTICION OF SUPPLIER ARCH DEPTICION OF SUPPLIER ARCH DEPTICION OF SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES BEACH DEPTICION OF SUPPLIER SUPPLIES OF		DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC. THE PAGE IN PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC. THE WHOBART, IN 46422 WHOBART, IN 46422 WHOBART, IN 46422 Continued From page 3 the facility deletical to ensure the menufood items were appropriate for the client's diabetic diet. The governing body failed to ensure the facility's nursing services monitored client #2's low and high blood sugar readings to nursing staff as outlined by risk plan/physician's orders. The governing body failed to ensure the facility staff administered the client's insulin as ordered, and to assess timely and/or follow-up an injury client #2'r exceived after a fall. The governing body failed to ensure staff tracked the client's food consumption, and/or failed to ensure staff tracked the client's weight loss, to ensure staff tracked the client's food consumption, and/or failed to ensure assessments of the client's weight loss, were completed. The governing body failed to ensure assessment of the client's weight loss, were completed. The governing body failed to ensure assessment of the client's weight loss were completed. The governing body failed to ensure the physician's orders. Please see W104. 4. The governing body failed to ensure the facility developed/maintained a record keeping system which documented and kept program plan information in the client's region information was administered per the physician's orders. Please see W111. This deficiency was cited on 5/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(a) (W 104) 43.410(a)(1) GOVERNING BODY WW 104)			15G245	B. WING			
### TXG ### (#CACH DEFICIENCY NUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE CROSS-R					4378 FOURTEENTH LN	1 077	03/2013
the facility's dietician to ensure the menu/food items were appropriate for the client's diabetic diet. The governing body falled to ensure the facility's nursing services monitored the client's meals to ensure the diabetic client received an adequate amount of food, and/or to ensure free foods were available/offered. The governing body failed to ensure the facility's nursing services monitored client #2's low and high blood sugar readings to nursing staff as outlined by risk plani/physician's orders. The governing body failed to ensure facility staff administered the client's insulin as ordered, and to assess timely and/or follow-up an injury client #2 received after a fall. The governing body failed to ensure the facility's nursing services monitored client #1's weight loss, to ensure staff tracked the client's food consumption, and/or failed to ensure assessments of the client's weight loss were completed. The governing body failed to ensure client #2's mecidation was administered per the physician's orders. Please see W104. 4. The governing body failed to ensure the facility developed/maintained a record keeping system which documented and ketp program plan information in the client's record, and/or which ensured client #2's record/personal information was safeguarded. Please see W111. This deficiency was cited on 5/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(a) (W 104) 483.410(a)(1) GOVERNING BODY W 104)	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
{W 104} 483.410(a)(1) GOVERNING BODY {W 104}	{W 102}	the facility's dietician items were appropriated items were appropriated items were appropriated items. The governing be facility's nursing service meals to ensure the coadequate amount of foods were available/body failed to ensure services monitored closugar readings to nurplan/physician's order failed to ensure facility client's insulin as order and/or follow-up an interest and food consumption, and assessments of the completed. The governing facility's nursing service weight loss, to ensure food consumption, and assessments of the completed. The governing body client #2's medication physician's orders. Put the governing body developed/maintained which documented are information in the clie ensured client #2's rewas safeguarded. Pleating the facility of	to ensure the menu/food te for the client's diabetic body failed to ensure the ces monitored the client's liabetic client received an body, and/or to ensure free offered. The governing the facility's nursing lient #2's low and high blood sing staff as outlined by risk rs. The governing body ry staff administered the lered, and to assess timely jury client #2 received after body failed to ensure the lient's weight loss were lient's weight loss were lient's weight loss were lerning body failed to ensure lease see W104. The facility dia record keeping system and kept program plan ant's record, and/or which cord/personal information lease see W111. The facility systemic plan of correction	{W 10	2}		
	{W 104}	483.410(a)(1) GOVER		{W 10	4}		8/2/13

	OF DEFICIENCIES CORRECTION				(X3) DATE SURVEY COMPLETED		
		15G245	B. WING _			07/0	R 03/2013
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0170	70/2010
ARC OF N	ORTHWEST INDIANA IN	C, THE		4378 FOURTEENTH LN HOBART, IN 46342			
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{W 104}	Continued From page	÷ 4	{W 10	04}			
	budget, and operating	g direction over the facility.					
	Based on observation review for 2 of 2 sample governing body failed and operating direction client #1 and #2's heat and not neglected. The exercise general policity over the facility to ensure services monitored standinistered medicate physician's orders. The exercise general policity over the facility to ensure fall/allegation of possional administrator and/or of #2. The governing both sides and policity fallegation of possional ministrator and/or of #2.	tions according to the the governing body failed to the governing body failed to the governing direction the governing direction the governing direction the governing direction for client the governing direction over the facility accounted for, feguarded client #2's					
	Findings include:						
	policy and operating of ensure the facility implies and written procedure client #2's diabetes as update/revise the clie governing body failed and operating direction the facility monitored and to ensure facility	dy failed to exercise general direction over the facility to olemented its written policy es to prevent neglect of as the facility neglected to nt's diabetic risk plan. The to exercise general policy on over the facility to ensure the client's diabetic menu staff offered the client a amount of food per the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		OATE SURVEY OMPLETED
		15G245	B. WING			R 07/03/2013
	ROVIDER OR SUPPLIER	NC, THE		STREET ADDRESS, CITY, STATE, ZIP C 4378 FOURTEENTH LN HOBART, IN 46342	CODE	07/03/2013
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{W 104}	to exercise general pover the facility to en client #2's low and hi outlined by the client program plan. The gexercise general policover the facility to enservices monitored the more frequent basis. to exercise general pover the facility to enaddressed the client and labs to prevent rhospitalizations/healt client's diabetes. The exercise general policover the facility to enits written policy and neglect of client #1 ir loss. Please see W1 2. The governing bopolicy and operating develop/maintain and documented and kep in the client's record, #2's record/personal safeguarded. Please 3. The governing bopolicy and operating ensure the facility rejinjury/possible neglerimmediately to the act Bureau of Developm (BDDS) per 460 IAC	The governing body failed colicy and operating direction sure the facility monitored gh blood sugar readings as 's physician's order and/or coverning body failed to cy and operating direction sure the facility's nursing the client's diabetes on a The governing body failed colicy and operating direction sure the facility aggressively as refusals of appointments ecurrence of potential the risks associated with the elegoverning body failed to cy and operating direction sure the facility implemented procedures to prevent a regard to the client's weight 49. dy failed to exercise general direction over the facility to ecord keeping system which of program plan information and/or which ensured client information was a see W111.	{W 1	04}		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		15G245	B. WING				R 12012
NAME OF PI	ROVIDER OR SUPPLIER	100240		S	TREET ADDRESS, CITY, STATE, ZIP CODE	07/	03/2013
ARC OF N	ORTHWEST INDIANA IN	IC, THE			378 FOURTEENTH LN OBART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 104}	Continued From page	e 6	{W 1	04}			
	policy and operating of ensure the facility's in revised/updated client diabetes. The govern general policy and opfacility to ensure the facility to ensured a diabetic mapproved by the facility menu/food items were diabetic diet. The governing exercise general policy over the facility to ensure the diabetic client recoffood, and/or to ensure available/offered. The exercise general policy over the facility to ensure available/offered. The exercise general policy over the facility to ensure facility to ensure facility to ensure facility to ensure facility in the facility's order facility in the facility's nursing sweight loss, to ensure food consumption, and assessments of the completed. Please sets the facility and operating densure client #2's mediated to exercise general policy and operating densure client #2's mediated to exercise general policy and operating densure client #2's mediated to exercise general policy and operating densure client #2's mediated to exercise general policy and operating densure client #2's mediated to exercise general policy and operating densure client #2's mediated to exercise general policy and operating densure client #2's mediated to exercise general policy and operating densure client #2's mediated to exercise general policy and operating densure client #2's mediated to exercise general policy and operating densure client #2's mediated to exercise general policy and operating densure client #2's mediated to exercise general policy and operating densure client #2's mediated to exercise general policy and operating densure client #2's mediated to exercise general policy and operating densure client #2's mediated to exercise general policy and operating densure client #2's mediated to exercise general policy and operating densure client #2's mediated to exercise general policy and operating densure client #2's mediated to exercise general policy and operating densure client #2's mediated to exercise general policy and operating densure client #2's mediated to exercise general pol	at #2's risk plan for his being body failed to exercise derating direction over the facility's nursing services enu was reviewed and/or ity's dietician to ensure the ele appropriate for the client's election is the facility's nursing election is the facility is the facility to ensure facility staff election in the facility of the facility to ensure elections monitored client #1's election is staff tracked the client's election is election.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	NC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	1 07700/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE COMPLETION
{W 104}		cited on 5/20/13. The facility a systemic plan of correction	{W 10	04}	
W 111		relop and maintain a m that documents the client's eatment, social information,	W ·	111	8/2/13
	Based on record rev failed for 1 of 2 samp develop/maintain a r documented and kep in the client's record	not met as evidenced by: view and interview, the facility oled clients (client #2), to ecord keeping system which ot program plan information , and to ensure the client's /record was safeguarded.			
	the facility's administ P.M A request for which contained clie Plan, Behavior Suppromonitoring document Plan, annual meeting behavioral risk plans Intellectual Disabilitie Coordinator (QIDP/S program record coul request for client #2' to the Volunteer Service which which is administration of the program	I's record was conducted at trative office on 7/1/13 at 1:40 client #2's program record nt #2's Individual Support fort Plan, training objective tation, Personal Centered grotes, medical and was made. The Qualified es Professional/Service CO indicated client #2's drot be located. A second as program record was made vices Coordinator (VSC) at condicated the facility could program record.			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION IG	(X3) DATE	LETED
		15G245	B. WING _		07//	≺ 03/2013
	ROVIDER OR SUPPLIER ORTHWEST INDIANA IN			STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 111	Continued From pag	e 8	W 1	111		
	7/1/13 at 2:30 P.M client #2's program re	QIDP/SC was conducted on The QIDP/SC indicated ecord should be accounted ted she did not know what ord.				
{W 122}	9-3-1(a) 483.420 CLIENT PR	OTECTIONS	{W 12	22}		8/2/13
	The facility must ens	ure that specific client ents are met.				
	Based on observation review, the facility fair Participation: Client Fampled clients (#1 aimplement its policy an eglect in regard to the needs. The facility an allegation of possible	not met as evidenced by: on, interview and record led to meet the Condition of Protections for 2 of 2 and #2). The facility failed to and procedures to prevent the clients' health/medical lso failed to report an e neglect in regard to a fall dministrator and/or to other				
	Findings include:					
	policy and written pro of client #2's diabete: update/revise the clie facility failed to monit and to ensure facility variety and adequate client's specified diet	to implement its written ocedures to prevent neglect is as the facility neglected to ent's diabetic risk plan. The for the client's diabetic menustaff offered the client are amount of food per the amount of food per the dient #2's low and high				

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NAME OF D	ROVIDER OR SUPPLIER	15G245	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	07	7/03/2013
NAME OF PI	ROVIDER OR SUPPLIER			4378 FOURTEENTH LN		
ARC OF N	ORTHWEST INDIANA IN	IC, THE		HOBART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{W 122}	Continued From page	9	{W 1	22}		
	by the client's physiciplan. The facility failed nursing services monon a more frequent by aggressively address appointments and lab potential hospitalization with the client's diabet implement its written prevent neglect of client's weight loss. For the facility failed residuely propossible neglects.	report a fall with ct, involving client #2,				
	Bureau of Developme (BDDS) per 460 IAC (Protective Services (Please see W153. This deficiency was called to implement a to prevent recurrence	ited on 6/4/13. The facility systemic plan of correction				
{W 149}	9-3-2(a) 483.420(d)(1) STAFF	TREATMENT OF CLIENTS	{W 1	49}		8/2/13
	policies and procedur	elop and implement written res that prohibit t or abuse of the client.				
	Based on observatio interview for 2 of 2 sa the facility neglected	not met as evidenced by: n, record review, and impled clients (#1 and #2), to implement its written cedures to prevent neglect				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15G245	B. WING		R 07/03/2013	
	ROVIDER OR SUPPLIER	INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		1 07/83/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
{W 149}	of client #2's diabete update/revise the clifacility neglected to high blood sugar reaclient's physician's of The facility neglected diabetic menu to en met the nutritional nueglected to ensure monitored the client frequent basis. The aggressively address appointments and lapotential hospitaliza with the client's diabeto implement its written prevent neglect of colient's weight loss. implement its policy possible neglect of colient's distribution in the colient's distribution in the colient is policy possible neglect of colient's distribution in the colient is policy possible neglect of colient's distribution in the colient is policy possible neglect of colient's distribution in the colient is	es as the facility neglected to ient's diabetic risk plan. The monitor client #2's low and adings as outlined by the order and/or program plan. It is sure it was approved and/or eeds of the client. The facility the facility's nursing services is diabetes on a more facility neglected to so the client's refusals of abs to prevent recurrence of tions/health risks associated betes. The facility neglected ten policy and procedures to lient #1 in regard to the The facility neglected to and procedures to prevent client #2 in regards to a fall incident was not reported to d/or to the Bureau of abilities Services. The facility neglected at the 13 from 5:00 P.M. until 7:10 to the group home the facility's I Disabilities a Coordinator (QIDP/SC) and tensed Practical Nurse (LPN) ome. At 5:15 P.M., the LPN	{W 149			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	0	X3) DATE SURVEY COMPLETED	
		15G245	B. WING _			R 07/03/2013	
	ROVIDER OR SUPPLIER	INC, THE	•	STREET ADDRESS, CITY, STATE, ZIF 4378 FOURTEENTH LN HOBART, IN 46342	CODE	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
{W 149}	#2 stated "You alread Staff #2 moved the reach. Staff #2 wer #2 returned, she pocup of water into the placed a small cup of client #2. Staff #cup of apple juice in client #2 took his sportice out of the both bowl. During the observation period, 1800 ADA diet men 6/1/13 ADA menu in menu day 6/1/13), of chicken, 1/2 cup of salad and mandaregular diet menu in have chicken, peas the dinner menu. Tindicate the facility's approved the 1800 home did not have posted. During the 7/2/13 of 10:20 AM and 11:30 program, client #2 af 2 had 1 slice of has andwich), approximative for appeared to still be finger and ate each The day service cafe	ge 11 or the pitcher of water. Staff ady had your 1/2 cup of water." pitcher out of client #2's at into the kitchen. When staff oured client #2 a second 1/2 are client's empty cup. Staff #1 of mandarin oranges in front 1 then poured client #2 1/2 a his cup to drink. At 6:58 PM, boon and retrieved a spoonful will before staff #2 could move at 7/1/13 above mentioned the facility had a June 2013 are posted in the kitchen. The adicated on 7/1/13 (actual client #2 was to have 3 ounces of rice, 1/2 cup of peas, 1 cup arin oranges. A posted 6/1/13 adicated the clients were to be being and ice cream for the June 2013 menu did not a dietician had signed and/or ADA menu items. The group an approved 7/1/13 menu approved 7/1/13 menu beservation period between 0 AM, at the day service at lunch at 11:05 AM. Client and 1 slice of bread (1/2 mately 12 potato chips and 1 after for his lunch. Client #2 hungry as the client licked his piece of crumb on the plate. Seteria staff or day service staff and any free foods (fillers)	{W 1	49}			
	which would allow t	he adult male client to feel full.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15G245	B. WING	/ING			R	
	OVIDER OR SUPPLIER ORTHWEST INDIANA IN			4378	EET ADDRESS, CITY, STATE, ZIP CODE 8 FOURTEENTH LN BART, IN 46342	1 077	03/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	program), was review The 7/1/13 Daily Log lunch/1800 calorie dia chicken nuggets, 1 se one 8 ounce cup of w A review of client #2's the facility's administr P.M. The record indicincluded, but were no Mellitus, Mental Retal Disease, and Hyperte Client #2's 5/21/13 pholient #2 was on an 1 concentrated sweets. physician's orders ince Before Breakfast & (a 5/21/13 order also ince PRN (as needed) for Hyper/hypoglycemia. Client #2's 6/27/13 pholient #2's insulin was "Novolog 70-30 Flexp [subcutaneous injection the "Site" form for client #2's fire form for client #	up home and the day yed on 7/2/13 at 10:40 AM. indicated client #2's 7/1/13 abetic diet consisted of 3 erving of french fries, and yeter. Serecord was conducted at rative office on 7/1/13 at 1:40 cated client #2's diagnoses yet limited to, Diabetes redation, Anxiety, Parkinson's ension. Anysician's orders indicated 800 calorie ADA diet with no Client #2's 5/21/13 dicated "Test Blood Sugar and) Before Dinner." The dicated "Test Blood Sugar signs or symptoms for "Anysician's order indicated se changed on 6/27/13 to yen to inject 15 units Sub-Q on] once daily (AM) before Sub-Q P.M. before supper." or Subcutaneous Injection 2 from 7/1/2013 to "7/1/137:00 A.MInsulin ye 12." The form indicated receive his ordered 15 units he A.M. on 7/1/13. yelog from 6/1/13 to 7/1/13 and received calls after hours bolood sugar levels which	{W 1	49}				

1, 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	· /	(X3) DATE SURVEY COMPLETED	
		15G245	B. WING_			R 07/03/2013	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	<u> </u>	07/03/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
{W 149}	"6/10/13 6:04 P.M.: back hr (hour) B/S." "6/16/13 6:36 P.M.: of hyperglycemiacc "6/17/13 5:56 P.M.: call in an hour. 7:40 symptoms will check #2] B/S 397 at 11:30 documentation on lo "6/24/13 5:37 P.M.: back in an hour 168. "6/28/13 5:55 P.M.: milk/eat call back in "6/30/13 6:38 P.M.: given, dinner." The record review in for client #2 dated 5/ client #2 was at risk blood sugar levels at come with poorly cor indicated the interve blood sugar daily." [client #2's] blood su this week May 28- Ju nurse). [Client #2's] scheduled for June 4 endocrinologist. Wh and if [client #2's] su and then call the nur risk plan indicated th client #2's risk plan at Review of client #2's from 5/4/12 to 7/2/13 Record" for client #2 nursing services neg client #2's high/low be	n hour7:20 B/S 89." [Client #2] B/S 68 eat call (Nothing else noted on log) [Client #2] B/S 361no signs ontinue to monitor." [Client #2] B/S 417 4 units P.M. B/S 453 no signs or back at 11:00 P.M[Client P.M" (No further g.) [Client #2] B/S 60 ate called " [Client #2] B/S 44 give 1 cup 1 hourB/S 148." [Client #2] B/S 324 4 units dicated a Diabetic Risk Plan 2013. The plan indicated for "having overly high or low and the health concerns that antrolled Diabetes." The plan antion of "staff will record his The risk plan indicated: "If gar is above 300 do nothing une 4, 2013 only (still call the follow-up appointment is 4, 2013 for evaluation per en blood sugar is checked gar is above 400 Call 911 se" Further review of the le facility neglected to revise	{W 14	49}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED		
		15G245	B. WING _			R 07/03/2013		
	ROVIDER OR SUPPLIER ORTHWEST INDIANA	INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	<u> </u>	0770072010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
{W 149}	indicated the facility client's physician in and/or high blood so Client #2's Cumulat the following medicated Client #2's complete at the had refused and the had refused to had refused to the had refused to the had refused to had refused to the had refused	The Cumulative Record also reglected to contact the regard to the client's low ugar levels. ive Medical Record indicated al refusals by client #2: rd indicated Client #2 was only imited echocardiogram after echocardiogram on 4/12/12. ulative medical record would not allow any part of his in retinoscopy. The record must either be sedated or don eyes 3 minutes prior to trist indicated, "It is of dire a dilated fundus exam as it een accomplished!!!" ulative medical record efused to have eye drops is eyes and the doctor's staff iplete his eye assessment. In doctor in the contact in the	{W 14	49}				

PRINTED: 08/13/2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15G245	B. WING			R 07/03/2013		
	ROVIDER OR SUPPLIER	IC, THE		43	TREET ADDRESS, CITY, STATE, ZIP CODE 378 FOURTEENTH LN IOBART, IN 46342		00.20.10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{W 149}	unable to complete h On 3/19/13, the cumulindicated client #2 wo to place electrodes of echocardiogram. On 3/19/13, client #2 On 3/13/13, the cumulindicated client #2's mursing quarterly. On 6/27/13, the cumulindicated the nurse with measurements of an non-compliance and refused his vitals. Client #2's Individual 2/28/13 indicated the interdisciplinary team client's refusals for do and tests. Client #2's medical record indicated the interdisciplinary team client's menu in regard to sugar levels. Client #2's menu in regard to sugar levels. Client #2's medical record indicated monitor client #2's medi	ulative medical record as uncooperative" and was is podiatry appointment. ulative medical record ould not allow the technician of do a scan for an a refused his blood work. ulative medical record efused his vitals during his a ulative medical record efused his vitals during his a unable to obtain injury due to client #2's further indicated client #2 Support Plan (ISP) dated facility and/or the client's neglected to address the octor appointments, labs, a ISP and/or cumulative ted the client's diabetes/blood to the client's diabetes/blood to the client's diabetes/blood to the client's diabetes/blood to the facility neglected to eals to ensure the diabetic te amount of food to eat ler foods to ensure adequate s.	{W 1	49}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15G245	B. WING _			R 07/03/2013	
	ROVIDER OR SUPPLIER	C, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		01700/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	TION
{W 149}	(QIDP/SC) was condicted. When asked if Team (IDT) met and a refusals for doctor appears the QIDP/SC stated "if there was documen indicate client #2's ID client #2's non-compli "No." An interview with staff 7/1/13 at 5:25 PM. So 2013 menu was in the had not been posted when asked if the died June 2013 menu staff #1 stated "yes, the died herself so we would herself	nal/Service Coordinator ucted on 7/1/13 at 2:30 client #2's Interdisciplinary addressed client #2's pointments, labs and tests, I'm not sure." When asked tation available for review to T had met and addressed ance, the QIDP/SC stated ance, the QIDP/SC stated ff #1 was conducted on taff #1 indicated the July a group home's office and for staff to use on 7/1/13. Itician had approved the fi were using on 7/1/13, staff etician made out the menulave an example to follow." It did not know why the the menu. Staff #1 indicated ed for client #2's salad as of have any salad/lettuce in ff #1 indicated client #2 was ition. In group home LPN was at 1:00 P.M The LPN indicated the client's MARs and	{W 1	49}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		15G245	B. WING _			R 07/03/2013	
	ROVIDER OR SUPPLIER	INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	<u> </u>	0770072010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{W 149}	(DHS) was conducted DHS indicated clien diabetes had not be indicated the plan si include what staff who blood sugar levels windicated facility state to client #2's 1800 At the group home state written. The DHS shooked at client #2's the client's "fluctuatifor appropriate portificated 3 chicken food to serve an additional and the fact of th	e Director of Health Services ed on 7/2/13 at 2:15 PM. The t #2's 5/14/13 risk plan for his en updated. The DHS hould have been updated to ere to do when client #2's were over 300. The DHS ff had been trained in regard ADA diet. The DHS indicated ff was following the diet as tated the facility had not menu/food items in regard to ng" blood sugar levels, and/or ons/amounts. The DHS nuggets would not be enough ult. acility's records was cility's records was cility's administrative office on At 1:10 P.M., a request for reports, BDDS reports and its group home dated 6/4/13 to At 1:30 P.M., the facility's pirector (BHD) stated "There BDDS), investigations or orts to submit." tion was conducted at the 13 from 5:00 P.M. until 7:10 g the group home, client #2 ving room love seat.	{W 14	49}			

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X3)	(X3) DATE SURVEY COMPLETED	
		15G245	B. WING_			R 07/03/2013	
	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	I	07/03/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
{W 149}	the QIDP stated she happened to him (cl group home nurse wastained the injury nurse stated "He fell When asked when the stated, "I'm not sure was reported, the number of the factor of the fall. A day program obsefacility owned day prog	ned the injury to his forehead, "had no idea" what ient #2). At 5:05 P.M., the vas asked how client #2 to his right forehead. The here at the group home." he injury occurred, the nurse "When asked if the incident urse stated "I don't know." rect Support Professional ucted at the group home on When asked how client #2 to his forehead, DSP #1 sure. DSP #1 further ed she heard he had fallen. all and injury had been oked in the file cabinet and ent/Accident report Number 69" sheet which indicated: oer of summaries 0StaffType: Other." The form did ppened, if a client was o details as to the incident	{W 14	19}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15G245	B. WING		R 07/03/2013		
	ROVIDER OR SUPPLIER	INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	1 01100/2010		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION		
{W 149}	home said he fell." injury were reported sure." When asked injury, DSP #4 state week now." A review of client #2 the facility's adminis P.M Review of clie Record" indicated the Nursing notation da Nurse reported res. nurse assessed pt a resp (respiration) evenoted, abrasion nick forehead unable to resident refused, vit to patient nurse. No noted." No further onoted in client #2's the client's injury to A review of the facil Pager Review" log of conducted at the fact 7/2/13 at 1:50 P.M pager log indicated: "6/23/13: 14th 8:00 scrape incident report documentation was An interview with the conducted at the fact 7/2/13 at 1:00 P.M indicated this incide	tated "I believe the group When asked if the fall and I, DSP #4 stated "I'm not how long client #2 had the ed "He's had it for a little over a 2's record was conducted at strative office on 7/1/13 at 1:40 ent #2's "Cumulative Medical ne following: ted 6/27/13: "PT (Patient) (resident) having fall, this alert, nonverbally responsive, ven, non labored, no distress sel size noted to right obtain measurements, rals refused, findings reported to bleeding, no further injuries documentation/follow-up was medical record in regards to his head. ity's "Residential Services dated 6/1/13 to 7/1/13 was cility's administrative office on Review of the nursing on call P.M[Client #2 initials] ort." No further	{W 149				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	RIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		15G245	B. WING _			R 07/03/2013	
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CO 4378 FOURTEENTH LN HOBART, IN 46342	DDE I	07/03/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE CORRECTION OF	ON SHOULD BE HE APPROPRIAT		
{W 149}	further indicated the i immediately reported within 24 hours to BD documentation was sindicate the mentione immediately reported reported to BDDS with The facility's policy arreviewed on 7/2/13 at 2/15/12 policy entitled Of Neglect And Abuse Northwest Indiana prexploitation of our clieneglect "as failure to the safety or care of the remedy the placing of poses a threat to his/. The policy indicated eincluded, but were not clients of medical carrand "adequate personal "adequate personal "adequate personal "adequate". Will immediately reponeglect or exploitation reporting procedure. Will meet current regure porting all incidents. 3. During the 7/1/13 5:00 PM and 7:10 PM #1 was tall and small big in size and hangin During the 7/1/13 obserceived two servings 3 pieces of chicken.	ncident should have been to the administrator and DS. No further ubmitted for review to d fall with injury was to the administrator and hin 24 hours. Independent of the facility's defined to consider and provide for the client and anticipate and for a client in a situation that there health and well being" Independent of the providing destruction of the client and anticipate and for a client in a situation that there health and well being" Independent of the providing destruction of the p	{W 1	49}			

PRINTED: 08/13/2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		15G245	B. WING			R 07/03/2013		
	ROVIDER OR SUPPLIER ORTHWEST INDIANA IN			4	STREET ADDRESS, CITY, STATE, ZIP CODE 378 FOURTEENTH LN HOBART, IN 46342	1 077	03/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{W 149}	PM. Client #1's 2012 indicated the following -May 2012 20-June 2012 12-July 2012 13-August 2012 17-October 2012 17-December 2012 17-December 2012 17-December 2012 17-December 2013 17-April 2013 17-Administration Recomposition	s reviewed on 7/1/13 at 2:16 and 2013 Weight Chart g (not all inclusive): 09 pounds 19 pounds 88 pounds 83 pounds 83 pounds 67 pounds 67 pounds 67 pounds 68 pounds 69 pounds 69 pounds 60 pounds 61 pounds 62 pounds 63 pounds 64 weight documented 65 Day Program Medication 65 d (MAR) was reviewed on 66 Client #1's June 2013 MAR 67 pounds 68 being weighed weekly (on any program. Client #1's 68 d the following weights: 68 d	{W 1	49}				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		15G245	B. WING			R 07/03/2013	
	ROVIDER OR SUPPLIER ORTHWEST INDIANA IN	IC, THE	•	4	STREET ADDRESS, CITY, STATE, ZIP CODE 1378 FOURTEENTH LN HOBART, IN 46342		0.2010
(X4) ID PREFIX TAG				X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 149}	regime as the client haggression. The 2/14 psychiatrist reduced was "no benefit from -3/19/13 Client #1 say continued treatment. there was mild improved behavior. -4/8/13 Client #1 saw The Cumulative Recoloss etiology unclear. indicated client #1's with the doctor's office. The standard of the say of the doctor's office. The say of the doctor's office. The say of the say	d to client #1's medication and demonstrated increased 4/13 consult indicated the client #1's Klonopin as there higher dose." w his psychiatrist for The consult sheet indicated wement in the client's his primary care doctor. ord indicated "Wt (weight)" The 4/8/13 record weight was 160 pounds at he record indicated client abs of "CBC (blood count), est), Random Level, ACTH s, U/A (urinalysis) & (and) gen test)." abs sent to [name of //Oncology record indicated d for mild chronic leukopenia if white blood cells) & ecreased number of platelets progressive weight loss" dicated client #1's labs for " The 4/25/13 note eighed 161 pounds at the ecord indicated "Plan- nedical doctor) to consider cans if continued wt loss nonths) to reassess. is medications.	{W 1	49}			

, ,		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		15G245	B. WING _			R 07/03/2013	
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP 4378 FOURTEENTH LN HOBART, IN 46342	CODE	07/03/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	DATE	
{W 149}	Continued From page	23	{W 1	49}			
	indicated "Pt (patient) The note indicated cli	w his neurologist. The note has aggressive behavior." ent #1 saw a psychiatrist.					
	The neurologist order 3 months.	ed lab work and to return in					
	-6/13/13 Note written indicated client #1's n client #1 was to follow	eurologist ordered labs and					
	annual physical. The "Physical (with) Wt test), Chem (blood te (urinalysis), ANA (Ant	w his family doctor for an 6/28/13 note indicated (weight) LossCBC (blood st), PSA (cancer test), U/A cinuclear antibiotics-immune s protein), CT (cat scan) abd ngs."					
	facility's nursing staff concerns in regard to between the months of 2013 and January 20 #1's cumulative recornursing staff neglecte	e Record indicated the neglected to document any the significant weight loss of March 2013 and April 13 to February 2013. Client d also indicated the facility's d to monitor/document any at #1's health, eating habits ts.					
	client #1's diet was ch 2/1/13. Client #1's 5/ indicated client #1 ha Control" diet prior to 2	· ·					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)) DATE SURVEY COMPLETED
		15G245	B. WING _			R 07/03/2013
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	I	07/03/2013
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{W 149}	Client #1's 6/13 phys	ician's order did not indicate to weigh client #1 and/or did ges in regards to ons.	{W 1-	49}		
	pounds on 10/22/12. weight was between pounds. The nutritio client #1 received a lassessment indicate portion control diet a Weight." The 10/22/indicate how often st Client #1's 10/22/12 indicated the facility facility's dietician of t loss. The assessme neglected to have the #1 in regard to the cli	d client #1 weighed 176 Client #1's ideal body 169 pounds and 186 nal assessment indicated Portion Control diet. The d client #1 was to continue a nd staff were to "Monitor 12 assessment did not aff were to weigh the client. Nutritional Assessment neglected to inform the he client's significant weight nt also indicated the facility e dietician re-assess client ient's weight loss for assist the client from further				
	plan indicated "[Cli weight loss. [Client # diet. [Client # 1] is not Baseline: [Client # 1' ideal body weight sh The risk plan indicate [client # 1] to eat all h have seconds. Staff food intake by size a food intake on tracking the Community Servintake is less than 1/ meal." The risk plan	Weight Management risk ent #1] had a history of #1] was on a portion control ow on a regular diet. s] current weight is 169. His ould be between 165-205." ed "Staff is to encourage is food and encourage him to are to monitor [client #1's] and report and document his ing sheet. Staff should call ices Nurse if [client #1's] food 4 of the entire meal at every indicated the tracking sheets				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15G245	B. WING_				R 03/2013
	ROVIDER OR SUPPLIER ORTHWEST INDIANA IN			STREET ADDRESS, CITY 4378 FOURTEENTH LI HOBART, IN 46342	N	1 077	03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION PRECTIVE ACTION SHOULD B PERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 149}	every Monday, and the review the tracking she risk plan indicated clie once a week at the daindicated the Health & the weights and send The 5/2013 risk plan in 3lbs (pounds) in a we Nurse will evaluate the client #1's doctor. The nurse would keep a reconsumption. Client #1's 2/13/13 Indicated the client's in neglected to meet and client #1's weight loss the annual survey. Client #1's 7/13 MAR indicated the facility in tracking sheet for clie 2013 as no Food Tracking sheet for cli	the facility's nurse would be the facility's nurse would be the fact at least monthly. The cent #1 would be weighed any program. The risk plan is Safety Tech would monitor them into the nurse weekly. Indicated "If plus or minus the fact the community Services the findings" and contact the risk plan indicated the ecord of client #1's food dividual Support Plan (ISP) interdisciplinary team (IDT) door document review of the since the initial citation at and/or program book the eglected to initiate a food in the fact the month of July the sking Sheet was present in for program book at the man records were reviewed for the cords were rev	{W 1	49}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15G245	B. WING _		_	l	R 03/2013
	ROVIDER OR SUPPLIER	IC, THE		STREET ADDRESS, CITY, S 4378 FOURTEENTH LN HOBART, IN 46342	STATE, ZIP CODE	1 077	55/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{W 149}	#1 on 7/2/13 at 10:55 and day program staffood intake. Day Proindicated client #1 did weight loss at the day administrative staff # aware if client #1 had weight. Interview with the He. (HST) on 7/2/13 at 11 was weighed at the dof each week. The Hclient #1's "weight reminus 1 to 2 pounds. stated client #1 was esconds if available." indicated the day protracking Sheet and fathe Health & Safety have any May weight Safety Tech indicated would have been turn Health & Safety Tech bring his lunch from the day program. The Health & Safety Tech bring his lunch from the day program. The Health & Safety Tech bring his lunch from the day program. The Health & Safety Tech bring his lunch from the day program. The Health & Safety Tech bring his lunch from the day a week where the day program. The Health & Safety Tech bring his lunch from the day program. The Health & Safety Tech bring his lunch from the day program. The Health & Safety Tech bring his lunch from the day program. The Health & Safety Tech bring his lunch from the day program of 6/28/13. The recommendation to second findicated she could find for the following for the following findicated she could findicated she could findicated she could findicated she could find for the following findicated she could find for the following findicated she could find for the following findicated she could findicated she could find for the following findicated she could find findicated she could findicated she could find findicated she could find findicated she cou	AM indicated facility staff f were to monitor client #1's gram administrative staff #1 I not have a risk plan for r program. Day Program I indicated she was not any concerns with his alth & (and) Safety Tech :03 AM indicated client #1 ay program on Wednesday ealth & Safety Tech stated mained the same plus or ' The Health & Safety Tech on a "regular diet. Offer The Health & Safety Tech gram staff filled out a Food exed it to the nurse weekly. Tech indicated she did not so for client #1. The Health & the May 2013 weights sed in to the nurse. The indicated client #1 would the group home except one the client had a lunch from the the ealth & Safety Tech indicated that #1 received seconds for Trice Coordinator (SC) on icated she took over the	{W 1	49}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		ATE SURVEY MPLETED
		15G245	B. WING _			R 07/03/2013
	ROVIDER OR SUPPLIER	NC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		7770372013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
{W 149}	the psychiatric appoints to the appoint she would schedule to see his psychiatris behavioral medication. Interview with LPN # indicated client #1 w seconds. LPN #1 in physician's orders in regular diet. LPN #1 not indicate client #1 LPN #1 indicated cliewas to be monitored sheet. LPN #1 indicated sheet. LPN #1 indicated she only ha for June 2013 from 6 told the group the hosheet for July 2013, have any blank form LPN #1 indicated the Coordinator made the indicated client #1 diregard to the client's medications. LPN # have gone to the docindicated she spoke the dietician came to LPN #1 indicated she spoke the dieticia	ere responsible for setting up intments and taking the iments. The SC indicated an appointment for client #1 st in regard to the client's ins and weight loss. 1 on 7/2/13 at 2:15 PM as on a regular diet with dicated client #1's 6/13 dicated client #1 was on a indicated the 6/13 order did was to receive seconds. Ent #1's food consumption and kept on a food tracking ated she did not have client tracking sheet. LPN #1 and the food tracking sheets 1/24/13 to 6/28/13. When sime did not have a tracking LPN #1 indicated she did not so to send to the group home. It is previous Service to the psychiatrist in weight loss and his 1 indicated client #1 was to cotor in June 2013. LPN #1 to the facility's dietician when a assess client #2's diabetes. In the total the dietician when a sesses client #2's diabetes. In the facility's dietician when a sesses client #2's diabetes. In the facility to dietician when a sesses client #2's diabetes. In the facility is dietician when a sesses client #2's diabetes.	{W 1-	· ·		
	LPN #1 indicated sh Coordinator about cl indicated she was no to the client's weight #1 "Normally only ge	weight loss at that time. e spoke to the Service ient #1's weight loss. LPN #1 ot aware of any IDT in regard loss. LPN #1 stated client ets seconds at dinner. Not " LPN #1 stated client #1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15G245	B. WING _			R 7/03/2013	
	ROVIDER OR SUPPLIER ORTHWEST INDIANA IN	IC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		7703/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
{W 149}	Continued From page 28		{W 1	1 9}			
		to eat seconds at ndicated client #1's family d about the client's weight					
	2/15/12 policy entitled Of Neglect And Abuse Northwest Indiana preexploitation of our clieneglect "as failure to the safety or care of the remedy the placing or poses a threat to his/ The policy indicated encluded, but were not served."	t 2:00 PM. The facility's d Policy For Handling Cases e indicated "1. The Arc phibits all abuse, neglect and ents" The policy defined to consider and provide for the client and anticipate and f a client in a situation that ther health and well being" examples of neglect to limited to,depriving e/treatment,not providing					
	_	sited on 5/20/13. The facility systemic plan of correction					
W 153	9-3-2(a) 483.420(d)(2) STAFF	TREATMENT OF CLIENTS	W 1	53		8/2/13	
	mistreatment, neglectinjuries of unknown simmediately to the ad	ource, are reported Iministrator or to other e with State law through					
	Based on observatio	not met as evidenced by: n, record review and failed for 1 of 1 fall with injury					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		X3) DATE SURVEY COMPLETED
		15G245	B. WING _			R 07/03/2013
	ROVIDER OR SUPPLIER	IC, THE		STREET ADDRESS, CITY, STATE, ZIP COD 4378 FOURTEENTH LN HOBART, IN 46342	E	01/100/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
W 153	/possible neglect, inv (client #2), to report in administrator and to the Disabilities Services (5) and to Adult Protes 12-10-3. Findings include: A review of the facility the facility's administrator. At 1:10 P.M., a incident reports, BDD for this group home of made. At 1:30 P.M., Health Director (BHD reportables (BDDS), incident reports to sure the facility was observed to have on the right side of his approximately the size Interviews with the QD isabilities Professio (QIDP/SC) and group conducted on 7/1/13 how client #2 sustain the QIDP stated she happened to him (cliegroup home nurse was sustained the injury to nurse stated "He fell When asked when the	olving 1 of 2 sampled clients mediately to the the Bureau of Developmental (BDDS) per 460 IAC 9-3-1(b) ective Services (APS) per IC y's records was conducted at rative office on 7/1/13 at 1:00 a request for all internal periods and investigations lated 6/4/13 to 7/1/13 was the facility's Behavioral periods are the same of investigations or internal bmit." on was conducted at the 3 from 5:00 P.M. until 7:10 the group home, client #2 are a bright red circular sore is forehead measuring the of a quarter. ualified Intellectual mal/Service Coordinator or home nurse were at 5:03 P.M When asked ed the injury to his forehead,	W	153		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		15G245	B. WING _			l	R 03/2013
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL)E	<u> </u>	00/2010
ARC OF N	ORTHWEST INDIANA IN	IC, THE		4378 FOURTEENTH LN HOBART, IN 46342			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
W 153	An interview with Dire (DSP) #1 was conduct 7/1/13 at 5:10 P.M sustained the injury to indicated she wasn't indicated she believe When asked if the fall reported, DSP #1 loo pulled out an "Incider tracking 19760-19760" 19760: 6/23numb assigned: [staff #5] not indicate what hap involved and gave not recorded on the form A review of client #2's was conducted at the 5:30 P.M Review of indicate a documente indicate client #2 sus indicate an assessment A day program obserfacility owned day program DS asked how client #2 storehead, DSP #4 stated week now." A review of client #2's was conducted at the 5:30 P.M. with day program obserfacility owned day program DS asked how client #2 storehead, DSP #4 stated week now."	ect Support Professional cted at the group home on When asked how client #2 or his forehead, DSP #1 sure. DSP #1 further d she heard he had fallen. I and injury had been ked in the file cabinet and nt/Accident report Number O" sheet which indicated: er of summaries 0 Staff Type: Other." The form did upened, if a client was a details as to the incident of group home medical record a group home on 7/1/13 at a felient #2's record did not tained an injury and did not	W 1	153			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		15G245	B. WING			R
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	07	/03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
W 153	P.M Review of clier Record" indicated the Nursing notation date Nurse reported res. (Inurse assessed pt ale resp (respiration) evenoted, abrasion nicke forehead unable to obresident refused, vital to patient nurse. No Inoted." No further doclient #2's medical remotation. A review of the facility Pager Review" log daconducted at the facil 7/2/13 at 1:50 P.M I pager log indicated: "6/23/13: 14th 8:00 F scrape incident report documentation was not an interview with the conducted at the facil 7/2/13 at 1:00 P.M indicated this incident administrator or BDD further indicated the incident and interview of the facil 7/2/13 at 1:00 P.M indicated the indicated th	at #2's "Cumulative Medical following: d 6/27/13: "PT (Patient) resident) having fall, this ent, nonverbally responsive, in, non labored, no distress I size noted to right obtain measurements, is refused, findings reported obleeding, no further injuries cumentation was noted in cord in regards to the above of the series of the following of the nursing on call of the cord in the log. P.M[Client #2 initials] The CIDP/SC and the nurse was sity's administrative office on the log. QIDP/SC and the nurse was sity's administrative office on the QIDP/SC and nurse was not reported to the series administrator and the administrator and	W 18	53		
{W 210}	9-3-2(a) 483.440(c)(3) INDIVII Within 30 days after a	DUAL PROGRAM PLAN	{W 21	0}		8/2/13

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		15G245	B. WING _			R 07/03/2013
	ROVIDER OR SUPPLIER	IC, THE		STREET ADDRESS, CITY, STATE, ZIP CO 4378 FOURTEENTH LN HOBART, IN 46342	DDE	07/03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA	DATE
{W 210}	assessments or reass	e 32 must perform accurate sessments as needed to ninary evaluation conducted	{W 2	10}		
	Based on observatio review for 1 of 2 sam interdisciplinary team	not met as evidenced by: n, interview and record pled clients (#2), the client's (IDT), failed to have the client in regard to the client's				
	Findings include:					
	5:00 PM and 7:10 PM #1 was tall and small big in size and hangir During the 7/1/13 obsreceived two servings 3 pieces of chicken.	dervation period between 1, at the group home, client in size. Client #1's shirt was ag off the client's body. dervation period, client #1 derivation of peas, rice, broccoli and client #1 also ate mandarin and a glass of Koolaid.				
		s reviewed on 7/1/13 at 2:16 and 2013 Weight Chart g (not all inclusive):				
	-June 2012 2 -July 2012 1 -August 2012 1 -September 2012 1 -October 2012 17 -November 2012 1 -December 2012 1 -January 2013 1	09 pounds 19 pounds 88 pounds 83 pounds 83 pounds 76 pounds 77 pounds 69 pounds 67 pounds 67 pounds				

* * *		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		15G245	B. WING _			R 07/03/2013		
	ROVIDER OR SUPPLIER	NC, THE		STREET ADDRESS, CITY, STATE, ZIP COD 4378 FOURTEENTH LN HOBART, IN 46342	E	07/03/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
{W 210}	-March 2013 -April 2013 -April 2013 -May 2013 -June 2013 Client #1's June 201 Administration Reco 7/2/13 at 11:00 AM. indicated client #1 w Wednesday) at the c 6/2013 MAR indicate -6/5/13 159 pounc -6/12/13 157 pounc -6/19/13 159 pounc -6/19/13 159 pounc -6/26/13 158 pounc Client #1's 2/1/13 ph client #1's diet was c 2/1/13. Client #1's 5 indicated client #1 ha Control" diet prior to Portion Control had beside it. Client #1's 6/13 phys how often staff were not include diet chan seconds/double port Client #1's 10/22/12 Assessment indicate pounds on 10/22/12 weight was between pounds. The nutritio	176 pounds 59 pounds No weight documented No weight documented 3 Day Program Medication rd (MAR) was reviewed on Client #1's June 2013 MAR as being weighed weekly (on day program. Client #1's red the following weights: dis	{W 2	10}				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		15G245	B. WING			R 07/03/2042		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 4378 FOURTEENTH LN HOBART, IN 46342	CODE	07/03/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA	DATE		
{W 210}	portion control diet ar Weight." The 10/22/1 indicate how often sta Client #1's 10/22/12 indicated the facility in facility's dietician of the loss. The assessmer failed to have the diet regard to the client's in recommendations to weight loss. Client #1's May 2013 plan indicated "[Client #1] is not Baseline: [Client #1] is not Baseline: [Client #1] is not Baseline: [Client #1] to eat all hit have seconds. Staff food intake by size ar food intake on tracking the Community Servicintake is less than 1/4 meal." The risk plan were to be submitted every Monday, and the review the tracking shrisk plan indicated client every Monday, and the treview the tracking shrisk plan indicated client every Monday, and the seconds as week at the definition once a week at the definition once	I client #1 was to continue a d staff were to "Monitor 2 assessment did not aff were to weigh the client. Nutritional Assessment eglected to inform the de client's significant weight at also indicated the facility ician re-assess client #1 in weight loss for assist the client from further. Weight Management risk ent #1] had a history of 1] was on a portion control of an a regular diet. If current weight is 169. His hald be between 165-205." d "Staff is to encourage is food and encourage him to are to monitor [client #1's] and report and document his g sheet. Staff should call ces Nurse if [client #1's] food of the entire meal at every indicated the tracking sheets to the Service Coordinator are facility's nurse would neets at least monthly. The ent #1 would be weighed asy program. The risk plan as Safety Tech would monitor them into the nurse weekly. Indicated "If plus or minus ek the Community Services e findings" and contact the sk plan indicated the nurse	{W 2	10}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15G245	B. WING			l	R 03/2013
	ROVIDER OR SUPPLIER ORTHWEST INDIANA IN			4	STREET ADDRESS, CITY, STATE, ZIP CODE 378 FOURTEENTH LN HOBART, IN 46342	<u> 011</u>	03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
{W 210}	Continued From page consumption. Interview with staff #1	e 35 on 7/1/13 at 5:25 PM	{W 2	210}			
	indicated client #1 wa with seconds.	s to receive a regular diet					
	indicated client #1 was seconds. LPN #1 ind physician's orders indregular diet. LPN #1 not indicate client #1 LPN #1 indicated she dietician when the dietician when the dietician assessed cli time. LPN #1 indicate	I on 7/2/13 at 2:15 PM Is on a regular diet with icated client #1's 6/13 licated client #1 was on a indicated the 6/13 order did was to receive seconds. I spoke to the facility's etician came to assess client I indicated she thought the ent #1's weight loss at that d client #1's family doctor the client's weight loss.					
	_	ited on 5/20/13. The facility systemic plan of correction					
{W 227}	9-3-4(a) 483.440(c)(4) INDIVII	DUAL PROGRAM PLAN	{W 2	227}			8/2/13
	objectives necessary as identified by the co	m plan states the specific to meet the client's needs, omprehensive assessment in (c)(3) of this section.					
	Based on record revi failed to include speci Individual Service Pla	not met as evidenced by: ew and interview, the facility effic objectives in the en (ISP) to address the edical appointments and labs					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		15G245	B. WING			07/03/2013
	ROVIDER OR SUPPLIER	NC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	,	31733,2310
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{W 227}	to prevent recurrence hospitalizations/heal client's diabetes for #2). Findings include: A review of client #2' 7/1/13 at 1:40 P.M #2's diagnoses includiabetes Mellitus, M. Parkinson's Disease Review of nurses no the "Cumulative Medindicated the followir #2: On 5/4/12, the recordable to complete a line had refused an ed. On 7/3/12, the cumulindicated Client #2 weye exam other than indicated Client #2 weye exam other than indicated Client #2 weye exam other than indicated Client #2 weye exam. The optometrimportance to have a has NEVER [sic] beef. On 8/3/12, the cumulindicated client #2 readministered into his	e of potential th risks associated with the 1 of 2 sampled clients (client "s record was conducted on The record indicated client ded, but were not limited to, ental Retardation, Anxiety, , and Hypertension. tes from 5/1/12 to 7/1/13 in dical Record" for client #2 ng medical refusals by client d indicated Client #2 was only mited echocardiogram after chocardiogram on 4/12/12. lative medical record yould not allow any part of his is retinoscopy. The record nust either be sedated or on eyes 3 minutes prior to rist indicated, "It is of dire a dilated fundus exam as it	{W 227	· ·		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	, ,	DATE SURVEY COMPLETED
		15G245	B. WING _			R 07/03/2013
	ROVIDER OR SUPPLIER	INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	ITY, STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{W 227}	client #2 refused to him during his nursi noted to have a small on 1/16/2013, the clindicated client #2 getting lab work and draw his blood. On 1/15/13, the cun indicated client #2 unable to complete On 3/19/13, the cun indicated client #2 to place electrodes echocardiogram. On 3/19/13, client # On 3/19/13, the cun indicated client #2's nursing quarterly. On 6/27/13, the cun indicated the nurse measurements of an on-compliance and refused his vitals. Client #2's Individual 2/28/13 indicated the interdisciplinary tear refusals for doctor as	mulative record indicated allow nurse to fully examine ng quarterly in which he was all cut on his tongue. cumulative medical record was uncooperative" while do the technician was unable to mulative medical record was uncooperative" and was his podiatry appointment.	{W 22	27}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		_		_		l	R	
		15G245	B. WING			07/	03/2013	
	ROVIDER OR SUPPLIER ORTHWEST INDIANA IN	C, THE		43	TREET ADDRESS, CITY, STATE, ZIP CODE 378 FOURTEENTH LN OBART, IN 46342			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{W 227}	(QIDP/SC) was condu P.M When asked if Team (IDT) met and a refusals for doctor ap the QIDP/SC stated " if there was documen indicate client #2's ID client #2's non-compli "No."	nal/Service Coordinator ucted on 7/1/13 at 2:30 client #2's Interdisciplinary addressed client #2's pointments, labs and tests, l'm not sure." When asked tation available for review to T had met and addressed fance, the QIDP/SC stated itted on 5/20/13. The facility systemic plan of correction .	{W 2				8/2/13	
	This CONDITION is a Based on observation review, the facility fail Participation: Health (sampled clients (#1 a Care Services failed to services met the heal it served. The facility failed to assess, more health care needs in a facility's Health Care client's doctor was conclient's low and/or hig facility's Health Care is	not met as evidenced by: n, interview and record ed to meet the Condition of Care Services for 2 of 2 nd #2). The facility's Health						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15G245	B. WING _			R 7/03/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		7/03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{W 318}	failed to assess clien. The facility's Health Censure a diabetic me as ordered, and to er was monitored and a Findings include: 1. The facility's Healtensure its nursing se #2's risk plan for his of Health Care Services menu was reviewed a facility's dietician to ewere appropriate for Health Care Services nursing services more ensure the diabetic camount of food and/cavailable/offered. The Services failed to ensure the diabetic camount of food and/cavailable/offered. The Services failed to ensure the client #2's basis and to notify the indicated by the client Health Care Services staff monitored client sugar readings as outplan/physician's orde Services failed to ensure staff to ensure staff tracke consumption, and/or	"s Health Care Services "t #2's injury after a fall timely." Care Services failed to dication was administered resure client #1's weight loss resessed. "th Care Services failed to rvices revised/updated client diabetes. The facility's railed to ensure a diabetic resure the menu/food items resure the menu/food items resure the client's meals to resure the client's meals to resure free foods were resure its nursing services diabetes on a more frequent reclient's physician as resure its nursing services diabetes on a more frequent reclient's physician as resure its nursing services diabetes on a more frequent reclient's physician as resure its nursing services diabetes on a more frequent reclient's physician as resure facility's Health Care resure facility staff	{W 3-	8}		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
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{W 318}	ensure medications w physician's orders for W368.	h Care Services failed to vere administered per the client #2. Please see ited on 5/20/13. The facility systemic plan of correction	E W}	18}			
{W 331}	9-3-6(a) 483.460(c) NURSING The facility must prov services in accordance	ide clients with nursing	{W 3	31}			8/2/13
	Based on observation interview for 2 of 2 sat the facility's nursing so revise/update client # The facility's nursing so diabetic menu was rethe facility's dietician sitems were appropriated diet. The facility's nurmonitor the client's much client received an adeand/or to ensure free available/offered. The failed to monitor client frequent basis and to as indicated by the client as indicated by the client high blood sugar outlined by risk plan/pfacility's nursing services failed.	mpled clients (#1 and #2), ervices failed to 2's risk plan for his diabetes. services failed to ensure a viewed and/or approved by to ensure the menu/food te for the client's diabetic rsing services failed to eals to ensure the diabetic equate amount of food					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{W 331}	assess and/or follow head. The facility's monitor client #1's w tracked the client's failed to ensure asseweight loss were confined by tracked the client's failed to ensure asseweight loss were confined by the group home on 7/1/2. 1. An evening obsegroup home on 7/1/2. Qualified Intellectual Professional/Service the group home Lice were at the group home. Observation period of (diabetic) diet. Staff which contained 3 opeas, 1/2 cup of rice cup of water. After of client #2 reached for #2 stated "You alread Staff #2 moved the preach. Staff #2 wend staff #2 wend staff #2 returned, shaff #2 returned, shaff #2 returned, shaff #2 returned, shaff #2 cup of water into #1 placed a small cut front of client #2. Staff #2 took happonful of rice out of could move the bow mentioned observat June 2013 1800 AD kitchen. The 6/1/13	rvation was conducted at the group home the group home the facility's IDisabilities e Coordinator (QIDP/SC) and ensed Practical Nurse (LPN) one. At 5:15 P.M., the LPN	{W 3	31}		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION	
{W 331}	1/2 cup of rice, 1/2 cand mandarin orang diet menu indicated chicken, peas, brook dinner menu. The candinate the facility's approved the 1800 home did not have a posted. During the 7/2/13 of 10:20 AM and 11:30 program, client #2 at 2 had 1 slice of has andwich), approxing styrofoam cup of was appeared to still be finger and ate each. The day service cafed did not offer the clie which would allow to 1/2 Client #2's Daily Log forth between the grogram), was revied the 7/1/13 Daily Log lunch/1800 calorie of chicken nuggets, 1 one 8 ounce cup of A review of client #2's continued the summer of the sum	cup of peas, 1 cup of salad ges. A posted 6/1/13 regular the clients were to have coli and ice cream for the June 2013 menu did not sidilician had signed and/or ADA menu items. The group an approved 7/1/13 menu beservation period between 20 AM, at the day service ate lunch at 11:05 AM. Client m, 1 slice of bread (1/2 mately 12 potato chips and 1 ater for his lunch. Client #2 hungry as the client licked his piece of crumb on the plate. Seteria staff or day service staff ent any free foods (fillers) the adult male client to feel full. In g Book (which went back and roup home and the day sewed on 7/2/13 at 10:40 AM. In g indicated client #2's 7/1/13 diabetic diet consisted of 3 serving of french fries, and	{W 33·			
	P.M. The record indincluded, but were removed the Mellitus, Mental Ref Disease, and Hyper Client #2's 5/21/13	dicated client #2's diagnoses not limited to, Diabetes tardation, Anxiety, Parkinson's				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	_	(X3) DATE COMP	SURVEY LETED
		15G245	B. WING _				⋜ 03/2013
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 331}	concentrated sweets. physician's orders in Before Breakfast & (a 5/21/13 order also in PRN (as needed) for Hyper/hypoglycemia. Client #2's 6/27/13 physiciant #2's insulin was "Novolog 70-30 Flex [subcutaneous injection breakfast and 5 units Review of the "Site for Site" form for client #7/31/2013 indicated: 12 unitsinjection citclient #2 failed to reconvolog 70-30 in the The nurse emergency indicated the nurse hiregarding client #2's lindicated the following "6/7/13 6:20 P.M.: [Consumer of the following foliant of the following foliant foli	Client #2's 5/21/13 licated "Test Blood Sugar and) Before Dinner." The dicated "Test Blood Sugar signs or symptoms for " Inysician's order indicated a changed on 6/27/13 to be to inject 15 units Sub-Q on] once daily (AM) before Sub-Q P.M. before supper." or Subcutaneous Injection 2 from 7/1/2013 to "7/1/137:00 A.MInsuling 12." The form indicated eive his ordered 15 units of A.M. on 7/1/13. And received calls after hours blood sugar levels which g (not all inclusive): Elient #2] B/S (blood sugar) hour7:20 B/S 89." Client #2] B/S 68 eat call (Nothing else noted on log) Client #2] B/S 361no signs intinue to monitor." Client #2] B/S 417 4 units P.M. B/S 453 no signs or back at 11:00 P.M[Client P.M" (No further J.) Client #2] B/S 60 ate called Client #2] B/S 60 ate called	{W 3	31}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15G245	B. WING		R 07/03/2013
	ROVIDER OR SUPPLIER	INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	1 01/103/2013
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{W 331}	The record review in for client #2 dated 5 client #2 was at risk blood sugar levels a come with poorly condicated the interve blood sugar daily." [client #2's] blood sugar daily." [client #2's] blood sugar daily." [client #2's] scheduled for June endocrinologist. Whand if [client #2's] sugard then call the nurisk plan indicated the facility from 5/4/12 to 7/2/1 Record" for client #2's risk plan after (Review of client #2's from 5/4/12 to 7/2/1 Record" for client #2's nursing services fail client #2's high/low was no documentated blood sugar levels. Indicated the facility physician in regard blood sugar levels. Client #2's Cumulate the following medicated Sugar levels. Client #2's Cumulate the following medicated Client #2's cumulated Client #2's risk plan after 6 review of client	indicated a Diabetic Risk Plan (2013). The plan indicated for "having overly high or low and the health concerns that introlled Diabetes." The plan ention of "staff will record his The risk plan indicated: "If ugar is above 300 do nothing lune 4, 2013 only (still call the follow-up appointment is 4, 2013 for evaluation per nen blood sugar is checked ugar is above 400 Call 911 rse" Further review of the he facility failed to revise client	{W 331		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				5 UM16		R	
		15G245	B. WING			07/	03/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA IN	IC, THE		4:	TREET ADDRESS, CITY, STATE, ZIP CODE 378 FOURTEENTH LN IOBART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 331}	has NEVER [sic] bee On 8/3/12, the cumul indicated client #2 ref administered into his were unable to comp The record indicated occurred on 8/31/12. On 9/22/12, the cumul indicated client #2 ref nursing quarterly. On 12/11/12, the cumulindicated client #2 refused to a him during his nursing noted to have a small On 1/16/2013, the cumulindicated client #2 "wighting lab work and draw his blood. On 1/15/13, the cumulindicated client #2 "wighting lab work and draw his blood. On 3/19/13, the cumulindicated client #2 work to place electrodes on echocardiogram. On 3/19/13, client #2 On 3/13/13, the cumulindicated client #2 work to place electrodes on echocardiogram.	ative medical record fused to have eye drops eyes and the doctor's staff lete his eye assessment. The dilated eye exam allative medical record fused his vitals for his fullative record indicated flow nurse to fully examine graph quarterly in which he was a cut on his tongue. In the technician was unable to the technician was uncooperative and was is podiatry appointment.	{W 3	331}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15G245	B. WING		R 07/03/2013	
	ROVIDER OR SUPPLIER	NC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342		1 01/00/2010	
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{W 331}	measurements of ar non-compliance and refused his vitals. Client #2's Individua 2/28/13 indicated the interdisciplinary tear client's refusals for cand tests. Client #2 medical record indic failed to monitor clie client's diabetes/blod ISP and/or cumulative the facility/nursing s #2's meals to ensure adequate amount of offered filler foods to food/meals. An interview with the Disabilities Profession (QIDP/SC) was comp. M When asked Team (IDT) met and refusals for doctor a the QIDP/SC stated if there was docume indicate client #2's I	ge 46 was unable to obtain in injury due to client #2's I further indicated client #2 I Support Plan (ISP) dated be facility and/or the client's in neglected to address the doctor appointments, labs, 's ISP and/or cumulative ated the nursing services int #2's menu in regard to the od sugar levels. Client #2's we medical record indicated bervices failed to monitor client be the diabetic client had an if food to eat and/or was in ensure adequate portions of Be Qualified Intellectual conal/Service Coordinator ducted on 7/1/13 at 2:30 if client #2's Interdisciplinary addressed client #2's ppointments, labs and tests, "I'm not sure." When asked contain available for review to DT had met and addressed colliance, the QIDP/SC stated	{W 331	,		
	7/1/13 at 5:25 PM. 2013 menu was in the had not been posted When asked if the during June 2013 menu sta	aff #1 was conducted on Staff #1 indicated the July ne group home's office and d for staff to use on 7/1/13. ietician had approved the aff were using on 7/1/13, staff dietician made out the menu				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		15G245	B. WING_			R 07/03/2013
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{W 331}	herself so we would herself so we would herself so we would herself state of the group home did not be group home. State of the group home of the group homes, or at the end were faxed into the owas not aware of any asked how many unit have been administed the LPN stated "15 unincident report had be the 7/1/13 medication. An interview with the (DHS) was conducted DHS indicated client diabetes had not been indicated the plan should be indicated the plan should be indicated facility staff to client #2's 1800 All the group home staff written. The DHS state looked at client #2's report of the client's "fluctuating for appropriate portion indicated 3 chicken in food to serve an adult."	ave an example to follow." de did not know why the the menu. Staff #1 indicated ted for client #2's salad as tot have any salad/lettuce in ff #1 indicated client #2 was tion. group home LPN was at 1:00 P.M The LPN de the client's MARs and she visited the group of the month when they ffice. The LPN indicated she medication errors. When s of Novolog 70-30 should ared on 7/1/13 at 7:00 A.M., hits." When asked if an the en submitted in regards to the error, the LPN stated "No." Director of Health Services don 7/2/13 at 2:15 PM. The #2's 5/14/13 risk plan for his an updated. The DHS build have been updated to the to do when client #2's there over 300. The DHS had been trained in regard to A diet. The DHS indicated the facility had not menu/food items in regard to gr blood sugar levels, and/or ans/amounts. The DHS uggets would not be enough	{W 3	31}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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{W 331}	group home on 7/1/13 P.M Upon entering was sitting on the living was sitting on the living was observed to have on the right side of his approximately the size. Interviews with the Qi Disabilities Profession (QIDP/SC) and group conducted on 7/1/13 how client #2 sustained the QIDP stated she happened to him (client group home nurse was sustained the injury to nurse stated "He fell I When asked when the stated, "I'm not sure." was reported, the nure was reported, the nure (DSP) #1 was conducted and interview with Direct (DSP) #1 was conducted at the injury to indicate she wasn't sindicated she believed A review of client #2's was conducted at the 5:30 P.M. Review of indicate a documenter indicate client #2 sust indicate the facility's reclient #2's injury at the A day program obserting the program obser	a from 5:00 P.M. until 7:10 the group home, client #2 ng room love seat. Client #2 e a bright red circular sore is forehead measuring e of a quarter. ualified Intellectual hal/Service Coordinator home nurse were at 5:03 P.M When asked ed the injury to his forehead, 'had no idea" what ent #2). At 5:05 P.M., the as asked how client #2 to his right forehead, the here at the group home." e injury occurred, the nurse When asked if the incident se stated "I don't know." ect Support Professional cted at the group home on When asked how client #2 to his forehead, DSP #1 sure. DSP #1 further d she heard he had fallen. a group home medical record group home on 7/1/13 at client #2's record did not d fall. The record did not trained an injury and did not hursing services assessed	{W 3	31}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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{W 331}	with day program D asked how client #2 forehead, DSP #4 shome said he fell." #2 had the injury, D little over a week not A review of client #2 the facility's adminis P.M Review of client Record" indicated the Nursing notation da Nurse reported res. nurse assessed ptaresp (respiration) evenoted, abrasion nick forehead unable to resident refused, vit to patient nurse. Not noted." No further of noted in client #2's the client's injury to A review of the facil Pager Review" log conducted at the fact 7/2/13 at 1:50 P.M pager log indicated: "6/23/13: 14th 8:00 scrape incident report documentation was An interview with the conducted at the fact 7/2/13 at 1:00 P.M. indicated this incides."	SP #4 was conducted. When a sustained the injury to his stated "I believe the group When asked how long client SP #4 stated "He's had it for a low." 2's record was conducted at strative office on 7/1/13 at 1:40 ent #2's "Cumulative Medical ne following: ted 6/27/13: "PT (Patient) (resident) having fall, this alert, nonverbally responsive, yen, non labored, no distress sel size noted to right obtain measurements, rals refused, findings reported to bleeding, no further injuries documentation/follow-up was medical record in regards to his head. ity's "Residential Services dated 6/1/13 to 7/1/13 was cility's administrative office on Review of the nursing on call P.M[Client #2 initials] ort." No further	{W 33	1}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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{W 331}	#2's injury to his head 3. During the 7/1/13 of 5:00 PM and 7:10 PM #1 was tall and small big in size and hangin During the 7/1/13 obs received two servings 3 pieces of chicken. oranges for dessert a Client #1's record was PM. Client #1's 2012 indicated the following -May 2012 20 -June 2012 2 -July 2012 18 -August 2012 18 -October 2012 17 -December 2012 17 -December 2012 17 -December 2012 17 -December 2013 17 -December 2013 17 -March 2013 17 -May 2013 15 -May 2013 No -June 2013 No Client #1's June 2013 Administration Record 7/2/13 at 11:00 AM. Orindicated client #1 was Wednesday) at the day	iment any follow-up of client I. observation period between I, at the group home, client in size. Client #1's shirt was ing off the client's body. ervation period, client #1 is of peas, rice, broccoli and Client #1 also ate mandarin ind a glass of Koolaid. s reviewed on 7/1/13 at 2:16 and 2013 Weight Chart	{W 3	331]	· · · · · · · · · · · · · · · · · · ·		
	-6/5/13 159 pounds	3					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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{W 331}	weights for May 2013 Client #1's Cumulative the following (not all in -2/14/13 Client #1 say 2/14/13 consult indicate medication was adderegime as the client haggression. The 2/14 psychiatrist reduced of was "no benefit from -3/19/13 Client #1 say continued treatment. There was mild improvibehavior. -4/8/13 Client #1 saw The Cumulative Recoloss etiology unclear. Indicated client #1's with the doctor's office. The H1's doctor ordered late Chem, TSH (thyroid to the thormone test), Lipids Ca-19-9 (cancer antigous cancer an	rovide any documented de Medical Record indicated inclusive): whis psychiatrist. The ated Inderal (behavior) in the client #1's medication and demonstrated increased with a consult indicated the client #1's Klonopin as there higher dose." whis psychiatrist for in the consult sheet indicated wement in the client's his primary care doctor. For indicated weight was 160 pounds at the record indicated client was of "CBC (blood count), est), Random Level, ACTH is, U/A (urinalysis) & (and) gen test)." abs sent to [name of concology record indicated defor mild chronic leukopenia.	{W 3	31}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		15G245	B. WING			07/	03/2013
	ROVIDER OR SUPPLIER	IC, THE		4	STREET ADDRESS, CITY, STATE, ZIP CODE 378 FOURTEENTH LN HOBART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 331}	in the blood) w/ (with) The 4/25/13 record in cancer were "normal. indicated client #1 we doctor's office. The readvise primary MD (nimaging w/ CT (cat) s w/o (without) reasonFollow-up in 3 mo (m-Possibly related to hi-0 (zero) sign of malige-6/6/13 Client #1 saw -6/13/13 Client #1 saw indicated "Pt (patient) The note indicated client mouth. -6/13/13 Note written indicated client #1 was to follow -6/28/13 Client #1 saw annual physical. The "Physical (with) Wt test), Chem (blood text (urinalysis), ANA (Ant test), CRP (measures (abdomen), pelvis, luicellent #1's Cumulative facility's nursing staff concerns in regard to between the months of 2013 and January 20	ecreased number of platelets progressive weight loss" dicated client #1's labs for " The 4/25/13 note eighed 161 pounds at the ecord indicated "Plannedical doctor) to consider cans if continued wt loss months) to reassess. is medications. gnancy." If his podiatrist. Whis neurologist. The note has aggressive behavior." ent #1 saw a psychiatrist. red lab work and to return in by the facility's LPN eurologist ordered labs and of up in 1 year. Whis family doctor for an 6/28/13 note indicated (weight) LossCBC (blood est), PSA (cancer test), U/A cinuclear antibiotics-immune is protein), CT (cat scan) abd	{W}	31}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	RIPLE CONSTRUCTION NG		COMPLETED	
		15G245	B. WING _			R 07/03/2013
	ROVIDER OR SUPPLIER	NC, THE	1	STREET ADDRESS, CITY, STATE, ZIF 4378 FOURTEENTH LN HOBART, IN 46342	CODE	37700/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A: CROSS-REFERENCED TO DEFICIE	CTION SHOULD B O THE APPROPRIA	DATE.
{W 331}	nursing staff did not in regard to client #1' monthly weights. Client #1's 2/1/13 phr client #1's diet was c 2/1/13. Client #1's 5 indicated client #1 ha Control" diet prior to Portion Control had beside it. Client #1's 6/13 physhow often staff were not include diet chan seconds/double portion. Client #1's 10/22/12. Assessment indicate pounds on 10/22/12. weight was between pounds. The nutrition client #1 received a Fassessment indicate portion control diet a Weight." The 10/22/indicate how often st Client #1's 10/22/12 indicated the facility facility's dietician of to loss. The assessment failed to have the die regard to the client's recommendations to weight loss. Client #1's May 2013.	weight indicated hanged to a regular diet on 2/1/13 as the order for D/C" (discontinue) written ician's order did not indicate to weigh client #1 and/or did ges in regards to ons. Annual Nutritional d client #1's ideal body 169 pounds and 186 nal assessment indicated Portion Control diet. The d client #1 was to continue a nd staff were to "Monitor 12 assessment did not aff were to weigh the client. Nutritional Assessment neglected to inform the he client's significant weight int also indicated the facility tician re-assess client #1 in	{W 3	31}		
		#1] was on a portion control				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		15G245	B. WING_			R 07/03/2013
	ROVIDER OR SUPPLIER	NC, THE		STREET ADDRESS, CITY, STATE, ZIP CO 4378 FOURTEENTH LN HOBART, IN 46342	DDE	01703/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
{W 331}	ideal body weight sh The risk plan indicate [client #1] to eat all h have seconds. Staff food intake by size a food intake on tracki the Community Serv intake is less than 1/ meal." The risk plan were to be submitted every Monday, and t review the tracking s risk plan indicated cl once a week at the cl indicated the Health the weights and send The 5/2013 risk plan 3lbs (pounds) in a w Nurse will evaluate t client's doctor. The would keep a record consumption. Client #1's 7/13 MAF indicated the facility tracking sheet for clie 2013 as no Food Tra the facility's MAR an group home. Client #1's Day Prog	ow on a regular diet. Is current weight is 169. His ould be between 165-205." ed "Staff is to encourage him to fare to monitor [client #1's] and report and document his ng sheet. Staff should call lices Nurse if [client #1's] food 44 of the entire meal at every indicated the tracking sheets at to the Service Coordinator the facility's nurse would sheets at least monthly. The lient #1 would be weighed day program. The risk plan & Safety Tech would monitor d them into the nurse weekly. Indicated "If plus or minus eek the Community Services he findings" and contact the risk plan indicated the nurse	{W 3	31}		
	May 2013 Weight May 2013 Weight May Interview with staff #	day program did not have the anagement risk plan. 1 on 7/1/13 at 5:25 PM as to receive a regular diet				

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15G245	B. WING _		_	R 07/03/2013	
	ROVIDER OR SUPPLIER	NC, THE		STREET ADDRESS, CITY, ST 4378 FOURTEENTH LN HOBART, IN 46342	TATE, ZIP CODE	01700/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	((EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)	DATE	
{W 331}	with seconds. Staff to track how much for Staff #1 indicated climiter Tracking Sheet should book. Interview with Day P #1 on 7/2/13 at 10:5 and day program stafood intake. Day Provindicated client #1 diversity weight loss at the day administrative staff #1 aware if client #1 had weight. Interview with the He 7/2/13 at 11:03 AM in weighed at the day preach week. The Heach week. The Heach week. The Heach week are minus 1 to 2 pounds #1 stated client #1 weight reminus 1 to 2 pounds #1 stated client #1 weight at the day program. The Health & Safety have any May weight Safety Tech indicated would have been tur Health & Safety Tech bring his lunch from day a week where the day program. The Health & The Health & Safety Tech bring his lunch from day a week where the day program. The Health & T	#1 indicated facility staff was not the client consumed/ate. ent #1's July 2013 Food Id be in the client's MAR rogram administrative staff for AM indicated facility staff if were to monitor client #1's orgram administrative staff #1 do not have a risk plan for y program. Day Program indicated she was not id any concerns with his ealth & (and) Safety Tech on indicated client #1 was program on Wednesday of ealth & Safety Tech stated in mained the same plus or "The Health & Safety Tech as on a "regular diet. Offer "The Health & Safety Tech indicated she did not its for client #1. The Health & dithe May 2013 weights need in to the nurse. The indicated client #1 would the group home except one in elient had a lunch from the ealth & Safety Tech indicated in the group seconds for "The Health & Safety Tech indicated client #1 would the group home except one e client had a lunch from the ealth & Safety Tech indicated in #1 received seconds for	{W 3	31}			
		rvice Coordinator (SC) on dicated she took over the					

AND DUAN OF CODDECTION IDENTIFICATION NUMBER		PLE CONSTRUCTION IG	(X3	(X3) DATE SURVEY COMPLETED		
		15G245	B. WING			R 07/03/2042
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4378 FOURTEENTH LN HOBART, IN 46342	l	07/03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWS CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
{W 331}	home on 6/28/13. The recommendation to solient's behavior med client's weight loss has indicated she could fifundicated the SCs we the psychiatric appoint clients to the appoint she would schedule at to see his psychiatrist behavioral medication. Interview with LPN #7 indicated client #1 was seconds. LPN #1 indicated client #1 indicated she only has for June 2013 from 60 told the group the hor sheet for July 2013, Lender any blank forms LPN #1 indicated the Coordinator made the indicated client #1 did regard to the client's indicated the appoint indicated she spoke to the dietician came to LPN #1 indicated she spoke to the dietician came to LPN #1 indicated she spoke to the dietician came to LPN #1 indicated she spoke to LPN #1 indicated s	e SC indicated the ee the psychiatrist about the fications in regard to the id not been done. The SC and any documentation client at since 3/13. The SC are responsible for setting up atments and taking the ments. The SC indicated an appointment for client #1 in regard to the client's as and weight loss. I on 7/2/13 at 2:15 PM as on a regular diet with icated client #1 was on a indicated the 6/13 order did was to receive seconds. In the food tracking the she did not have client acking sheet. LPN #1 at the food tracking sheets (24/13 to 6/28/13. When the did not have a tracking PN #1 indicated she did not to send to the group home. In the previous Service at tracking form. LPN #1 at not go to the psychiatrist in weight loss and his indicated client #1 was to too in June 2013. LPN #1 the facility's dietician when assess client #2's diabetes.	{W 33	31}		

PRINTED: 08/13/2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15G245	B. WING			R	
NAME OF P	ROVIDER OR SUPPLIER	136243	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	07/	03/2013
ARC OF N	ORTHWEST INDIANA IN	IC, THE		4:	378 FOURTEENTH LN IOBART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 331}	seconds at dinner. N LPN #1 stated client a eat seconds at break client #1 family docto client's weight loss. This deficiency was of failed to implement a to prevent recurrence	#1 "Normally only gets ot breakfast and lunch." #1 would be "too excited to fast." LPN #1 indicated r was concerned about the ited on 5/20/13. The facility systemic plan of correction	{W 3				0/0/40
{W 368}	that all drugs are adm the physician's orders	administration must assure ninistered in compliance with	{W 3	308}			8/2/13
	failed for 1 of 2 samp ensure medications we physician's orders. Findings include: A review of client #2's the group home on 7/ record indicated clien but were not limited to Retardation, Anxiety, Hypertension. Client #2's 7/1/2013 to reviewed and indicated levels were monitored	ew and interview, the facility led clients (client #2) to were administered per the serecord was conducted at 1/13 at 5:30 P.M The t #2's diagnoses included, p. Diabetes Mellitus, Mental Parkinson's Disease, and 10 7/31/2013 MARs were ed client #2's blood glucose d in the A.M. (morning), The MARs indicated client					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		15G245	B. WING			R	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 4378 FOURTEENTH LN HOBART, IN 46342	DDE	07/03/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIAT		
{W 368}	#2 was prescribed No inject "15 units Sub-Conce daily (AM) befor Sub-Q P.M. before su Review of the "Site for Site" form for client #2 7/31/2013 indicated: 12 unitsinjection citreceive his ordered 1 the A.M. The record review incomplete for client #2 dated 5/2 client #2 was at risk for blood sugar levels and come with poorly con An interview with the conducted on 7/2/13 indicated she reviewed medical record when homes, or at the end were faxed into the or was not aware of any asked how many unith have been administer the LPN stated "15 units deficiency was contained to the	povolog 70-30 Flexpen to [subcutaneous injection] to breakfast and 5 units upper." or Subcutaneous Injection 2 from 7/1/2013 to "7/1/137:00 A.MInsulin to 12." Client #2 did not 5 units of Novolog 70-30 in dicated a Diabetic Risk Plan 2013. The plan indicated for "having overly high or low did the health concerns that throlled Diabetes." group home LPN was at 1:00 P.M The LPN to the client's MARs and she visited the group of the month when they ffice. The LPN indicated she is of Novolog 70-30 should red on 7/1/13 at 7:00 A.M., nits."	{W 3	668}			